

## McLaren Print System Order

Order No: 79382 Reprint Previous Order No: 5506  
 Order Date: 2023-09-13  
 User: Whitney Calderon  
 Phone: 5178193366

Ship Location: McLaren Dewitt Family Medicine  
 12805 Escanaba Dr, Suite 1  
 Dewitt, Mi 48820

### Forms

Quantity: 500  
 Paragon Dept No: 55514  
 Dept Name: McLaren Dewitt Family Medicine  
 Company Number: 810

Order Total Price: 117.00

Item Number: MM-474  
 Item Description: Influenza Consent Form  
 Revision Date: 8/2021  
 Print: 1 sided black and white  
 Paper: 2 Part (White, Yellow)  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info: This form must be ordered with DCH-0457

**McLaren**  
MEDICAL GROUP

**INFLUENZA CONSENT & ADMINISTRATION FORM**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Sex  Male  Female

Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Primary Care Provider (PCP) \_\_\_\_\_

**Not all individuals receiving the influenza vaccine can be safely vaccinated. Please complete the following questions to evaluate any contraindications to the influenza vaccine.**

- Do you have any known life-threatening allergies?  Yes  No  
 If yes, describe the allergen: \_\_\_\_\_
- Have you ever had a severe reaction to a previous influenza vaccine or any of its components?  Yes  No  
 If yes, describe the reaction: \_\_\_\_\_
- Do you have a fever or active illness?  Yes  No
- Do you have a past history of Guillain-Barre Syndrome?  Yes  No
- Do you have a history of seizures or convulsing? (for intranasal administration only)  Yes  No

As with any medication, there are risks and possible side effects/reactions. Side effects/reactions of influenza vaccine are generally mild, usually occur soon after vaccination and can persist for 1-2 days. In rare cases, side effects/reactions of influenza vaccine may include empty/hoarse and even death. If you think you are having a severe reaction or other emergency, SEEK MEDICAL CARE IMMEDIATELY.

I have received and reviewed the Influenza Vaccine Information Statement (VIS/7021) and have had the opportunity to ask questions. I have been advised to receive each administration for at least 17 months following vaccination. I understand the benefits and the risks of the influenza vaccine as described. I hereby agree to receive and hold McLaren Medical Group, its employees, agents and representatives, harmless from further responsibility with regard to my receiving the vaccine. I request the influenza vaccine to be given to me or to the person named for whom I am authorized to sign.

Signature of Patient or Authorized Representative (include relationship) \_\_\_\_\_ Date \_\_\_\_\_  
(If Under 18, Signature of Parent or Legal Guardian Required - include relationship)

**Check staff:** For any YES response and an active patient, review with the provider. Otherwise, refer patient back to their PCP. I have reviewed and authorize vaccine administration. Provider Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

McLaren Medical Group will continue to administer your influenza vaccine today due to a contraindication. Please take a copy of this form to your Primary Care Provider.

**FOR MEDICARE PATIENTS ONLY**

I request that this provider be paid authorized Medicare benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits for related services. I understand that I am responsible for the charges if my Medicare coverage is not appropriate. Medicare Number \_\_\_\_\_

Patient Signature \_\_\_\_\_  Payment to Patient  Payment to Provider

Site of Injection:  Right Deloid  Left Deloid  Right Anterolateral Thigh  Left Anterolateral Thigh  Intranasal

Lot Number \_\_\_\_\_ Manufacturer \_\_\_\_\_ Expiration Date \_\_\_\_\_

Administered by \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

INFLUENZA CONSENT FORM - Original - Cassin Casey - Patient MM-474 Rev. 8/2021